

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

1 0 - 1 6

2. STATE:

Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2010

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201

7. FEDERAL BUDGET IMPACT:

a. FFY 10 \$ -0-

b. FFY 11 \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, page 6d

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):
Attachment 4.19-B, page 6d

10. SUBJECT OF AMENDMENT:

Public Clinic Services - reimbursement

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Stephen Fitton, Director

Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Stephen Fitton

13. TYPED NAME:
Stephen Fitton

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
September 17, 2010

16. RETURN TO:

Medical Services Administration
Program/Eligibility Policy Division - Federal Liaison Unit
Capitol Commons Center - 7th Floor
400 South Pine
Lansing, Michigan 48933

Attn: Nancy Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPE NAME:

22. TITLE:

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)***

15. Public Clinic Services

Reimbursement for Public Clinic Services, other than dental services, is at reasonable and allowable full costs as described below.

The methodology for achieving full cost reimbursement is fee for service and Medicaid managed care billings which are subsequently cost settled. To participate in this methodology, qualified providers must supply the Program with a Medicaid cost report which lists medical costs, revenue, and encounters for services covered by this section. The cost reposts must be in compliance with 2 CFR 225: Cost Principles for State, Local and Indian Tribal governments (OMB Circular A-87). Based on the Medicaid cost report, a provider specific encounter rate is determined and used to make initial full-cost payments which are made on a quarterly basis, as applicable.

Annual cost settlements are performed to ensure that the initial payments were made at reasonable and allowable full cost. As necessitated by the cost settlement process, any financial adjustments are made with the provider. The settlements are performed for each public clinic and for each fiscal year which ends after April 1, 1991.

A combination of local funds and state general funds provides the basis for reimbursing providers and for claiming federal financial participation in OF expenditures made in accordance with 42 CFR 433.51

TN NO.: 10-16

Approval Date: _____

Effective Date: 10/01/2009

Supersedes

TN No.: 09- 13